Summary of evidence from the literature

- Implement reminder/recall protocols. This is simply outreach by phone, text, mail, or email to parents that a child is due for their immunization.
  - When reminder/recall hasn’t worked, a home visit from a community health worker or even a nurse to give the vaccination at home has been shown effective but is resource intensive.
  - The Colorado Chapter American Academy of Pediatrics have standardized template letters, phone scripts, text messages, and social media posts (see Source List) to encourage patients and families to return to the office for vaccinations during COVID-19.
- Start vaccine education with mothers during pregnancy. Vaccine hesitancy is known to be greater in first time mothers and research has shown that childhood vaccination decision making begins prenatally.
- Train providers on effective communication. A presumptive approach can be more effective than a participatory approach. Present vaccination as the norm.
- Generate EHR reports or population health tool reports to determine how many patients are leaving the practice each day without receiving their due immunizations.
  - Due for an immunization without an upcoming appointment
  - Due for an immunization with an upcoming appointment
  - Due soon (<14 days) for an immunization / vaccination
- Motivate staff to find opportunities to reach patients who are not up-to-date.

Evidence-based Guidelines and Model Programs

- The American Academy of Pediatrics guidelines address practice level changes to improve childhood immunization rate. The website includes links to resources and materials that can help, including example
The recommendations include:
  o Create standing orders for vaccinations to support top-of-performance care.
  o Develop provider prompts in the EMR.
  o Hold family friendly office hours for vaccine clinics (evenings and weekends).
  o Assign an immunization champion at the practice.
  o Provide a strong recommendation to parents at the time of visit using vaccine-confident language in a scripted response.
  o Give providers feedback on their individual immunization rates and provide benchmarking against practice, regional, and state level data.
  o Educate patients and their parents through appropriate health-literate and cultural-competent language and materials.
  o Include all recommended vaccinations at every visit (no missed opportunities), including sick-child and chronic care visits.
  o Hold team huddles and incorporate immunization planning through mapped workflows.
  o Prioritize the 15-18 month well child visit as a way to get 4th DTAP and other missed shots.

- The Assessment, Feedback, Incentives, and eXchange of information (AFIX) framework is a multicomponent provider-based intervention. The AFIX framework is strongly recommended by the Task Force on Community Preventive Services and CDC. [https://www.cdc.gov/vaccines/pubs/pinkbook/strat.html#afix](https://www.cdc.gov/vaccines/pubs/pinkbook/strat.html#afix)

**Best Practice from HC Top Performer:**
- No missed opportunity for immunization at every scheduled visit (possible exceptions for urgent care and sick visits).
- Use of Ohio Impact Statewide Immunization Information System (ImpactSIIS) bidirectional reporting. User may generate a registry report to interface all due vaccines into EHR.
- Use EHR and Population Health tool to run gap reports and get kids scheduled who have shots due or overdue.
- Develop standing orders.
- Share provider performance regularly and unblinded with providers.
Sources:

Centerpoint Health Interview, August 2020


Additional Source

Summary of evidence from the literature

The literature contains strong evidence that the following key interventions can improve cervical cancer screening. Details of these interventions and how they can be used in a multicomponent approach are detailed in the resources linked below.

- Patient outreach through reminder calls or letters inviting the patient to schedule cervical cancer screening are effective at increasing screening rates.
- Provider-oriented interventions including assessment and feedback and reminder and recall systems are effective at improving a “no opportunities missed” approach with cervical cancer screenings. Provider incentives have not been found effective.
- Patient engagement with community health workers/care managers has been shown to be effective. These interactions focus on increasing demand for cervical cancer screening (group education sessions, one-on-one education sessions, and client reminders) and reducing structural barriers (e.g., transportation).
- Clinic organizational factors can have an impact. Chuang, et al. (2019) studied UDS and AHRF data from 984 FQHCs and found that provider-to-patient ratios were significantly associated with high cervical and colon cancer screening rates, suggesting that carefully managing patient panels, promoting team-based care, and reducing provider burnout may help increase cancer screening rates. Somewhat counterintuitively, staff-to-patient ratios did not have an effect on cancer screening.
Evidence-based Guidelines and Model Programs:

- CPSTF The Community Guide is a good summary of up-to-date literature on what is effective to increase cervical cancer screening (as well as breast, colon, and skin cancers). The guide highlights the importance of multicomponent interventions. These typically have a patient-oriented and a provider-oriented component. [https://www.thecommunityguide.org/content/task-force-findings-cancer-prevention-and-control](https://www.thecommunityguide.org/content/task-force-findings-cancer-prevention-and-control)

- Bharel, et al. (2015) published their results from a cervical cancer screening QI project at a large FQHC in Boston with a large homeless population using a 6-component approach. Screening rates increased from 19% to 50% over a 5-year period. Their approach included:
  - **Point-of-service care**: “Trained nurses and providers to treat every medical encounter as an opportunity for cervical cancer screening.”
  - **Multidisciplinary screening**: “Behavioral health and primary care services are integrated with a team focus on preventive health needs. Nonclinical staff and nurses became part of the inquiry process for cervical cancer screening. Front desk staff at outreach sites assisted patients with preventive care needs assessment surveys.”
  - **Health maintenance form in the EMR**: “Updated health maintenance form in the EHR enhanced visual trigger for providers. Up-to-date measures were in green and out-of-date measures were in red. Quality measures could be assessed by a multidisciplinary team including RNs and MAs, during all visits through the EHR. Documentation of data in structured fields allowed for efficient aggregation and analysis for data-driven process improvement initiatives.”
  - **Process Improvement**: Standardized pap test trays were stocked and stationed in all clinic rooms to improve efficiency. Staff members were encouraged to share best practices and pilot process improvement cycles.
  - **Population Management**: Teams, sites, and providers distributed transparent quality indicator comparative dashboards. Patient registries were used by staff across sites during team case conferencing, in team huddles, and in direct street and shelter outreach to encourage screening. Front desk staff combined
appointment reminder reports and preventive care reports in patient outreach calls.”

- **Provider and patient education**: “Provider: experts in the field of cervical cancer screening were invited to grand rounds and other teaching events. Providers were offered refresher courses on cervical cancer screening techniques. Patient: Pap test day health fairs offered same-day pap tests. Culturally and linguistically appropriate brochures and posters were created and disseminated by quality team.”

**Trauma-informed Approach to Cervical Cancer Screening**

The National Healthcare for the Homeless Council presentation is a good resource for everyone, but in particular clinics that do healthcare for the homeless and have large numbers of women that have experienced trauma. Contains good examples of how to talk with women about common objections to getting a pap done and how to implement a “no opportunities missed” approach.


**Best Practice from HC Top Performers:**

- Adopt a no missed opportunity approach with pap smears. If they are needed, do them whenever a patient is present regardless of reason for the visit.
- Create events and outreach efforts during Cervical Health Awareness Month in January to promote cervical cancer screening. Use social media to promote the services and engage patients.
- Utilize gap reports or huddle reports to identify patients due for their pap.
- Use care coordinators to reach out to patients who are overdue or will soon be due for screening. Send follow up letters if patients are not reached by phone.
- Use a visit communication tool such as a “rooming ticket” that summarizes the preventive maintenance the patient is due. The patient receives the ticket from the front desk when they check in and then it “follows” them throughout the visit with each point of contact
able to discuss their preventive health needs. The ticket then goes back to the front desk on check out with follow up scheduling information.

- Focus on prevention messaging with patients and staff from day one.
- Complete a three-month recall for all missed pap appointments.
- Share unblinded performance data with providers at least quarterly.
- Create an audit process for all pap release of information requests to ensure results are received.

**Sources:**


Community Family Health Center, Interview August 2020.


Muskingum Valley Health Center, Interview August 2020
OACHC UDS Bottom 4 Clinical Guidance

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Summary of evidence from the literature

The literature points to the following key interventions for improving HIV linkage to care. Aspects of these features are detailed in the resources linked below.

- Active monitoring of linkage to care. This involves use of a registry of patients with positive tests and outreach to patients or the HIV providers they were referred to and confirming follow up/linkage
- Creating a machine-readable field in EMRs to document linkage status can help with registry development for tracking
- Intensive outreach and care management for assistance with health system navigation, reminders, and transportation assistance.
- HIV partner services- establishing relationships with HIV specialists in the community to make referrals more seamless and improve communication regarding kept/missed appointments
- Point of care HIV testing can improve linkage to care by allowing counseling and referral to be done immediately while the patient is in the office after getting results. This eliminates the opportunity for patients to no-show their appointment for test results.

Evidence-based Guidelines and Model Programs

- Anti-Retroviral Treatment and Access to Services (ARTAS) is the standard of care for HIV linkage to care. ARTAS is an individual-level, multi-session, time-limited intervention, based on the Strengths-based Case Management model, designed to link patients recently diagnosed with HIV to medical care. [https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS](https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS)
• TargetHIV: Integrating HIV Innovative Practices (IHIP) has a large number of resources including case studies, webinars, and other materials for various steps on the HIV continuum of care, including linkage to care. Includes general linkage to care information as well as linkage to care for specific populations of interest. https://targethiv.org/ihip

  o The HIV Continuum Manual has very good sections on linkage to care:
    ▪ The Ohio-based Care Alliance Health Center’s Assess, Test, Link: Achieve Success (ATLAS) Program model. While this was a program focusing on linkage upon discharge from the prison system, there are relevant lessons that can be adapted by clinics. https://targethiv.org/sites/default/files/file-upload/resources/ihip_HIV_Care_Continuum_Manual_Improving_Health_Outcomes_Moving_Patients_Along_the_HIV_Care_Continuum_and_Beyond.pdf
    ▪ The Virginia-based Special Project of National Significance Patient Navigation for HIV linkage to care is a health department focused model, that could be adapted for clinics following clients they screen. https://targethiv.org/sites/default/files/file-upload/resources/ihip_SPNS_IHIP_PatientNavigation_Linkage_FINAL508.pdf

• National HIV Curriculum HIV Linkage to Care Module https://www.hiv.uw.edu/go/screening-diagnosis/linkage-care

Training Primary Care Providers to manage HIV

As HIV treatment is becoming simplified, it is more feasible for HIV to be managed in primary care. Clinics in areas with low or no access to specialists, may consider building that capacity themselves. This would allow improved HIV linkage to care, by keeping it all “in house.” Training resources for primary care providers are interested in learning how to treat HIV themselves include:

https://aidsetc.org/training
https://www.matec.info/programs/ohio
http://www.acthiv.org/
Best Practice from HC Top Performer:

- Track all HIV referrals as urgent and assign a specific staff member to follow up on open referrals within 7 days.
- Develop and utilize standing orders for HIV treatment labs to get labs done asap (within 48 hrs) of informing the patient of their positive result.
- Establish 1-2 referral mechanisms/patterns that work for most patients.
- If your Primary Care Providers are willing, do training so that they can do rapid start ART with Biktarvy.
- Offer 4th Generation HIV tests in the office, including point of care tests.

Sources:


Equitas Health Center Interview August 2020
Summary of evidence from the literature

For all FQHCs:

- Improve preconception healthcare.
  - Promote LARC to prevent unintended pregnancies.
  - Identify women wanting to become pregnant for preconception counseling.
  - Educate postpartum women about the importance of birth-spacing and provide LARC to reduce short birth-spacing.
  - Educate women wanting to become pregnant on the importance of maintaining a healthy weight, healthy lifestyle (diet and physical activity), immunization status, good chronic disease management, cessation from tobacco, alcohol, and drugs.
- Identify pregnant women early
  - Reduce barriers to accessing pregnancy testing, including advertising their availability

For FQHCs that do not provide prenatal care:

- Improve early entry into prenatal care and support navigation to prenatal care
  - Create a pregnancy navigation group (including care managers and even designated administrative staff) that follow up with the patient to ensure they get scheduled and keep their prenatal care appointments and address any structural barriers to care.
Screen pregnant women and women who want/plan to become pregnant for high-risk pregnancy. Use care management to offer high-risk pregnancies extra support.

For FQHCs that do provide prenatal care:

- Promote and educate on use of progesterone for the prevention of preterm birth (either 17 alpha hydroxyprogesterone caproate (17P) or vaginal progesterone).
  - See the Ohio Prenatal Quality Collaborative’s Progesterone Project for resources: [https://www.opqc.net/projects/progesterone](https://www.opqc.net/projects/progesterone)
- Implement Centering Pregnancy group prenatal care. This is an evidence-based prenatal care model that has been shown to improve birth outcomes, including health birthweight. Has been promoted by ODH. [https://www.centeringhealthcare.org/what-we-do/centering-pregnancy](https://www.centeringhealthcare.org/what-we-do/centering-pregnancy)

Evidence-based Guidelines and Model Programs

- Ohio Prenatal Quality Collaborative’s Preterm birth education and prevention resources for patients: [https://www.opqc.net/patients/preterm-birth-and-prevention](https://www.opqc.net/patients/preterm-birth-and-prevention)
- Ohio Prenatal Quality Collaborative’s Preterm Birth Prevention resources for providers: [https://www.opqc.net/patients-providers/%20Preterm%20Birth%20and%20Prevention](https://www.opqc.net/patients-providers/%20Preterm%20Birth%20and%20Prevention)
- The Before, Between, & Beyond Pregnancy Resource Guide for Clinicians: [https://beforeandbeyond.org/toolkit/](https://beforeandbeyond.org/toolkit/)

Best Practices from HC Top Performer:

- Have a policy of all pregnant patients seeking PNC will be scheduled within 1 wk of call or request.
- Start a 1st Trimester Matters Initiative (staff shirts, posters, patient fliers, staff meeting emphasis, etc). Use all staff and departments to help schedule the first prenatal visit. (See sample materials from NEON)
  - 1st Trimester Matters Campaign
1st Trimester Matters Flyer
1st Trimester Matters Poster

- Have an appointed staff member to track all positive pregnancy tests to ensure patients kept first appointment and track all pregnant patients monthly for kept/missed appointments, test results, birth weights and trimester of entry into care.
- Schedule post-partum visit and well-child check with mom after delivery but before she leaves the hospital. Capture birth weight as part of this process.
- Connect all moms with home visiting programs during pregnancy and after.
- Use centering pregnancy model as much as possible for prenatal visits.

Sources:


NEON Interview, August 2020